Do not staple in this area.

Uniform Medical Plan
Your health. Your plan. Your choice.

Claim Form

Instructions

1. Submit one claim per patient.
2. Attach itemized bills, including patient's name, date of service, diagnosis, and charge.
3. Retirees covered by Medicare who do not have an itemized bill need only attach a copy of the Explanation of Medicare Benefits (EOMB) form. Be sure to complete Section 3 of this form to avoid claims delay.
4. If services were rendered by a Uniform Medical Plan network provider and if the Uniform Medical Plan is the primary plan (meaning it pays before any other plan), you need not file a claim.
5. Mail your completed claim to: **Uniform Medical Plan, P.O. Box 34850, Seattle, WA 98124-1850.**
6. Do not use this form for prescription drug or dental claims.

Questions? Employees: 1-800-762-6004; (425) 670-3000 Seattle
Retirees: 1-800-352-3968; (425) 670-3150 Seattle

Section 1 – Subscriber Information

A. Uniform Medical Plan Identification No. ____

B. Subscriber Name _____ (Last Name / First Name / M.I.) Birth Date ____/____/____ (Mo. / Day / Yr.)

C. Subscriber Home Address _____ (Street Address)

_____ (City / State / ZIP Code + 4 / Work Phone Number / Home Phone Number)

D. Has your address changed since your last claim? ❑ Yes ❑ No

Section 2 – Patient Information *Do not complete if patient is subscriber. Go to Section 3.*

A. Patient Name _____ (Last Name / First Name / M.I.) Birth Date ____/____/____ (Mo. / Day / Yr.)

B. Relationship to subscriber
- ❑ Spouse
- ❑ Other Specify: _____
- ❑ Dependent stepchild
- ❑ Dependent child under age 20

C. Is patient employed? ❑ Yes, full-time ❑ Yes, part-time ❑ No

If yes: _____ (Name of Employer)

_____ (City / State / ZIP Code + 4 / Employer's Phone Number)

Section 3 – Provider Information

Complete this section if the provider information is not included on the bill.

Provider Name	Provider Name
Specialty	Specialty
Address	Address
City / State / ZIP Code + 4	City / State / ZIP Code + 4
Tax ID Number (if known)	Tax ID Number (if known)

PLEASE COMPLETE REVERSE SIDE

Section 4 – Accident or Work-Related Injury Information

A. Is this claim the result of a work-related illness or injury? ❑ Yes ❑ No

B. Is this claim due to any accident or injury? ❑ Yes ❑ No
If you answered no to both questions, go to Section 5.

C. Was illness or injury due to ❑ Auto Accident ❑ Other Specify: _____

D. Date accident occurred _____ /_____ /_____
Mo. Day Yr.

E. Was a police report filed? ❑ Yes ❑ No ***If yes, you must submit a copy of the police report with this claim.***

F. If auto accident, was patient wearing a seatbelt? ❑ Yes ❑ No
If motorcycle or bicycle accident, was patient wearing a helmet? ❑ Yes ❑ No

G. Explain where and how the illness or injury occurred _____

_____

H. Auto or home owner's insurance company _____
Name of Insurer

_____
Street Address City State ZIP Code + 4 Phone Number

I. Insurance company of any third party involved with this loss _____
Name of Insurer

_____
Street Address City State ZIP Code + 4 Phone Number

J. Do you intend to seek repayment of medical expenses and/or work time lost for you or your dependent?
❑ Yes ❑ No Uncertain at this time

K. Will you file for any disability benefits? ❑ Yes ❑ No Uncertain at this time

L. Will you contact an attorney in this matter? ❑ Yes ❑ No Uncertain at this time

M. If yes: _____
Name of Attorney Street Address City State ZIP Code + 4 Phone Number

Section 5 – Other Coverage

A. Are patient's medical expenses covered by another employer's group health insurance, welfare, or government plan? ❑ Yes ❑ No
If yes, and the other plan is primary, a copy of the Explanation of Benefits from the other plan must be attached.

If yes, name of subscriber carrying other group coverage _____
Name

_____
Street Address City State ZIP Code + 4

_____
Name of Plan Group Number

B. Is patient covered by Medicare? ❑ Yes ❑ No
If no, go to Section 6. If yes, is a copy of the Explanation of Medicare Benefits enclosed?

C. What type of Medicare coverage does patient have? ❑ Part A (Hospital) ❑ Part B (Physician)

D. Is Medicare coverage due to kidney disease? ❑ Yes ❑ No

E. Is Medicare coverage due to disability? ❑ Yes ❑ No

Section 6 – Authorization to Pay

Have you paid for these charges? ❑ Yes ❑ No ***Network providers are paid directly.***

I certify this information is correct and authorize its release as required for administration of this claim.
Please note that pursuant to Chapter 70.02 RCW, personal information that you may be required to submit to the Uniform Medical Plan, including medical records, cannot be disclosed without your express written consent. Other information is subject to the Health Care Authority's Public Records and Privacy Protections policy and is available upon request by calling 360-923-2822 or online at www.wa.gov/hca/ump.

_____ _____
Signature of Subscriber/Patient (Parent, if minor) Date